DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/13/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185168	A. BUILDING _____ B. WING _____	09/29/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH AND REHABILITATION CENTER	706 N MAGNOLIA ST CLANTON AL 35037 TOMPKINS

RECEIVED
OCT 22 2010
Division of Health Care
Southern Enforcement Branch

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on September 27-29, 2010. Deficient practice was identified with the highest scope and severity at "F" level, with no substandard quality of care identified.	F 000	The submission of this plan of correction does not constitute an admission by the provider of any fact or conclusion set forth in the Statement of Deficiency. This plan is being submitted because it is required by law.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow physician's orders for one (1) of twenty-three (23) sampled residents. Resident #2 had physician's orders for food and fluid restrictions; however, the resident was served food that was on the restricted list and more fluids than the amount allotted. The findings include: A review of the medical record for resident #2 revealed the resident was admitted to the facility on March 17, 2010, with diagnoses that included Chronic Kidney Disease, Hypertension, Osteoporosis, and Diabetes. Further review revealed current physician's orders restricting fluids for resident #2 to 1400 cubic centimeters (cc) of fluids daily. In addition, resident #2 had physician's orders for a Renal Consistent Carbohydrate Diet with no tomatoes, no potatoes, and no dried beans. Observations of the evening meal on September 27, 2010, at 7:15 p.m. EDT, revealed resident #2	F 281	F281 1) Resident #2's water pitcher was refilled to the proper level. Potatoes were removed from resident #2's tray and resident was provided with a substitute. On 10/19/10 Hydration Nurse reeducated resident #2 on the amounts of fluid she was allotted throughout the day. 2) No other residents in the building are on a fluid restricted diet. On 10/25/2010 at tray line all diet tray cards will bechecked for accuracy by the dietary manager. All physician orders are being followed by the dietary staff members. 3) On 10/22/2010 Dietician educated Dietary staff members on the importance of following the tray cards. On 11/5/2010 the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mitzy Cook — TITLE: Administrator — (X6) DATE: 10/21/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Received Time Oct. 22. 2010 10:50AM No. 3674

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MONROE HEALTH AND REHABILITATION CENTER	706 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167

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F 281	Continued From page 1 was served a meal that included sweet potatoes, 240 cc of coffee, and 120 cc of juice. In addition, the resident's water pitcher was three-fourths full of water and was available for the resident to drink. An interview with resident #2 conducted at 7:25 p.m. on September 27, 2010, revealed the resident was "not sure" if her/his fluids were limited. The resident stated, "I don't know how much I can have." An interview with Certified Nursing Assistant (CNA) #1 conducted on September 27, 2010, at 7:26 p.m., revealed CNA #1 had served the supper tray to resident #2. CNA #1 stated he/she did not look at the tray card to check for accuracy and was not aware the resident was not permitted to have potatoes. An interview with CNA #2 conducted on September 27, 2010, at 7:30 p.m., revealed CNA #2 served the resident a cup of coffee in addition to the juice served on the tray. CNA #2 stated, "I knew the resident's fluids were limited, but we don't really pay attention to it." An interview with Licensed Practical Nurse (LPN) #1 conducted on September 27, 2010, at 7:30 p.m., revealed LPN #1 saw the coffee and juice on the tray, but assumed the resident had received the appropriate amount of fluid and did not question it. An interview with the Dietary Manager conducted on September 27, 2010, at 7:33 p.m., revealed the staff responsible for checking trays for accuracy was newly hired, and "just missed it."	F 281	DON will reeducate all nursing and dietary staff members on the importance of following the facility's fluid restriction policy. Nursing staff members will be reeducated on the importance of checking tray cards while serving residents' trays. 4) Dietary manager or her designee will observe tray line weekly for four weeks and then monthly thereafter to ensure that tray cards are being followed by the dietary staff members. Hydration nurse will perform a QA at least weekly to assure that we are following fluid restriction orders. Results will be reviewed by the administrator weekly and will be reported to the QA committee quarterly.	11/12/2010

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F 281	Continued From page 2 An interview with Registered Nurse (RN) #1, who was responsible for hydration, was conducted on September 28, 2010, at 8:30 a.m., and revealed the staff was aware of the resident's fluid limitations and was not supposed to fill the water pitcher up.	F 281	F 318 1) An order for Occupational Therapy related to resident #5s left hand was obtained on 10/4/2010. The resident is receiving occupational therapy five times per week with a new plan of care for contractures and preventative measures. 2) By 11/8/2010 all residents will be screened by the DON or ADON to assure that any declines in ROM are identified and the residents' plan of care is individualized for residents needs. Necessary changes will be made. 3) On 10/20/10 the Director of Nursing educated ADON on the proper way of assessing resident's joint mobility and on documenting results on the Joint Mobility Assessment. On 10/21/10 DON will educate ADON and therapy staff members on individualizing restorative interventions according to resident's limitation. All residents will be screened	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one (1) of twenty-three (23) sampled residents received appropriate treatment and services to prevent a decrease in range of motion. Resident #5 was assessed to have impaired range of motion of the left hand; however, there was no evidence the facility had developed interventions to improve or maintain the resident's mobility status. The findings include: A review of the medical record revealed resident #5 was admitted to the facility on February 4, 2000, with diagnoses of Nonpsychotic Brain Syndrome, Chronic Obstructive Pulmonary Disease, Senile Dementia, Hypertension, and Thoracic Aortic Aneurysm. A review of the significant change comprehensive assessment	F 318		

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F 318	Continued From page 3 completed on April 12, 2010, revealed resident #5 was assessed to have limited range of motion of the left hand and to require extensive to total assistance of staff for transfers, bed mobility, hygiene, and bathing. A review of the quarterly joint mobility and restorative screen conducted on April 5, 2010, revealed resident #5 was assessed to be able to passively make a fist and fully open the right hand; however, the resident was identified to keep the left hand clinched. The screening also noted the left and right hands were within functional limitation (WFL). The screen noted WFL was defined as having 75 to 100 percent of available range of motion. A review of the restorative care plan for resident #5 revealed the facility had identified the resident to be at risk for contracture development due to weakness. Interventions included to provide active assist range of motion (ROM) exercises to bilateral upper and lower extremities at least 15 minutes daily and to report any decline in ROM to the charge nurse or restorative nurse for further evaluation. However, there was no evidence the facility had developed individualized interventions to address the resident's impaired ROM of the hands. Resident #5 was observed on September 27, 2010, at 3:30 p.m., at 4:30 p.m., and at 5:40 p.m., to be lying in bed on a wedged mattress with a pillow underneath the resident's knees. A handroll was observed to be lying on the resident's bedside table. A skin assessment conducted on September 28, 2010, at 10:55 a.m., revealed the facility staff nurse was able to flex resident #5's right hand with some stiffness	F 318	quarterly. Individualized interventions will be put on the care plan. DON, ADON and therapy will meet monthly to discuss any issues. 4) DON will perform audit on at least five residents per month to ensure resident has been assessed accurately and care planned for their specific problems. DON will report results to the QA committee quarterly.	11/12/2010

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F 318	Continued From page 4 noted. The resident's left hand was noted to be closed in a fist and when the nurse attempted to open the resident's hand the resident called out "OH." The nurse was unable to flex the third, fourth, and fifth fingers of the resident's left hand. An interview conducted with CNA #3 on September 28, 2010, at 1:50 p.m., revealed ROM exercises were provided daily for resident #5 during bathing. CNA #3 stated hand rolls or other interventions had not been provided for the resident. CNA #3 further stated the resident would "scream" when staff attempted to straighten the fingers of the resident's left hand. An interview conducted with the Restorative Coordinator (RC) on September 28, 2010, at 12:55 p.m., revealed the RC was responsible to conduct quarterly contracture measurements of the residents and to develop restorative interventions to prevent/maintain joint mobility. The RC stated resident #5 would "jerk" back when staff attempted to straighten the fingers of the resident's left hand and some stiffness had been noted in the resident's right hand. The RC further stated the resident's restorative program consisted of ambulation, communication, and active assist ROM of both upper/lower extremities. The RC stated the therapy representatives also participated in the resident's restorative plan of care, but no referrals had been made to have a therapy screening of the resident's hands for further modes of treatment. A review of the facility's policy/procedure related to Restorative Nursing (no date) revealed each resident was required to be screened upon admission, and at least every three months for the need for restorative nursing. The	F 318		

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F 318	Continued From page 5 policy/procedure further noted that an individualized plan of care was required to be developed to prevent deterioration, and to maintain/improve the resident's current level of function.	F 318	F 364 1) Trays sampled by the survey team and the dietary manager during inspection were given a new plate of warm food. The pureed bread recipe was revised for the next meal. 2) The week of 10/4/2010 Dietary Manager, Administrator, and DON performed tray audits to determine the temperature and taste of the food served. Any concerns were addressed immediately. At the resident council on 11/1/2010 the dietary manager will speak to the resident council about food temperatures and taste of food. Any concerns will be addressed immediately. 3) On 10/8/2010 Dietician educated all staff members on the importance of serving tasty meals. Temperature recording logs and Tray Delivery Policy were revised by the dietician. On 10/22/2010 Dietician and dietary manager will reeducate dietary staff on the Serving Temperature	
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to serve palatable foods at appropriate temperatures for residents on the A, B, and D Wings during the lunch and dinner meals on September 27, 2010, and the breakfast meal on September 28, 2010. The findings include: Observation of the lunch meal on the A Wing, on September 27, 2010, revealed the first meal tray was served at 1:32 p.m. (Eastern Daylight Time). A facility staff person removed the last tray from the cart at 2:02 p.m., 30 minutes later. Two surveyors intercepted the food tray to conduct a palatability test with the participation of the Dietary Manager (DM). The temperature of the pureed meal was as follows: fish - 98 degrees Fahrenheit, mashed potatoes - 108 degrees Fahrenheit, macaroni and cheese - 108 degrees Fahrenheit, Vitamin D milk - 50 degrees Fahrenheit, and a vanilla shake supplement - 60	F 364		

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F 364	Continued From page 6 degrees Fahrenheit. A surveyor and the Dietary Manager conducted palatability tests of the meal with both noting the fish, potatoes, and macaroni and cheese were warm and bland to taste. The Dietary Manager stated the milk and shake were warm and not as cold as they should have been. Observations were conducted on September 27, 2010, during the dinner meal tray pass on the D Wing. Observation revealed the first meal tray was passed at 6:32 p.m., and the last meal tray was passed at 7:02 p.m., 30 minutes later. The last meal tray was intercepted by two surveyors along with the presence of the Dietary Manager. Temperatures were taken of the fortified liquid diet meal. Temperatures were noted as follows: sweet potatoes - 112 degrees Fahrenheit, ham - 120 degrees Fahrenheit, bread with milk - 80 degrees Fahrenheit, milkshake - 56 degrees Fahrenheit, and Vitamin D milk - 48 degrees Fahrenheit. After a palatability test was completed, the Dietary Manager stated the food was barely warm, was bland, and he/she would have sent the food back to the kitchen at these temperatures. Further observations were conducted on September 28, 2010, at 8:43 a.m., on the B Wing during the breakfast meal. Observation revealed the last meal tray was intercepted at 9:12 a.m., due to the extended timeframe of meal delivery to the residents. The meal tray was intercepted by two surveyors and the DM. Temperatures of the puree diet were as follows: oatmeal - 118 degrees Fahrenheit, bacon - 102 degrees Fahrenheit, eggs - 90 degrees Fahrenheit, gravy - 88 degrees Fahrenheit, and Vitamin D milk - 48 degrees Fahrenheit. The Dietary Manager stated the food temperatures were not acceptable.	F 364	Policy and on the Tray Delivery Policy. Dietary staff will be educated on the revised temperature recording logs and procedures. Dietary Manager ordered new wells and lids for the steam table, dietary staff members are ensuring that the plate warmer is kept at its warmest temperature, cold products are put in the freezer prior to meals being served, and steam table element was fixed by maintenance staff. The order of tray pass has been changed so that trays are served in a timely manner. 4) Dietary Manager, Administrator, and DON will perform test tray audits weekly. Results will be reviewed by the NAR committee weekly. Dietary Manager will report results to the quarterly QA committee.	11/12/2010

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F 364	Continued From page 7 During the Resident Group interview conducted on September 28, 2010, at 4:00 p.m. - 4:30 p.m. (EDT), residents #14, #21, #22, and #23 revealed the food was cold when served to these residents. The residents stated they had reported these concerns to facility staff but nothing had been done to correct the identified problem with cold food temperatures. An interview with the Dietary Manager (DM) and Administrator conducted on September 28, 2010, at 10:40 a.m., revealed they did not check temperatures or conduct palatability tests at the point of service to ensure the food temperatures and taste of the foods were acceptable. They further revealed the facility did not have a policy regarding food temperatures at point of service or regarding a required timeframe to deliver trays to residents. Interview with the Dietitian on September 28, 2010, at 9:28 a.m., revealed meal tray pass should be completed in 10-15 minutes.	F 364		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371	F371 1) On 9/28/2010 Dietary Manager disposed of all outdated or unlabeled food and drinks. Dietary Manager called vendor and requested new ice cream freezer. On 9/29/2010 Vendor supplied kitchen with new ice cream machine. 2) On 9/28/2010 Dietary manager checked entire refrigerator and freezer for outdated and unlabeled products. No additional items were found.	

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F 371	Continued From page 8 by: Based on observation and interview, the facility failed to store, prepare, and distribute foods under sanitary conditions. The findings include: Observations were conducted with the Dietary Manager of the kitchen refrigerator on September 28, 2010, at 10:25 a.m. (EDT). The following items were observed to be outdated and stored in the kitchen refrigerator: One container of diet pears, dated September 18, 2010. One container of Parmesan cheese, dated May 11, 2010. One jar sweet relish, opened and partially used, not dated. One-half container of shredded cheese, dated September 15, 2010. One pitcher of diet orange drink, dated September 21, 2010. One pitcher of diet lemonade, dated September 16, 2010. One container thickened dairy milk, dated September 17, 2010. One container sweetened tea, dated September 24, 2010. One container thickened punch, dated September 24, 2010. Observation of the kitchen conducted on September 28, 2010, at 10:45 a.m., revealed an ice cream freezer with the lid broken, seal not intact, and foam inside of the lid visible. The ice cream freezer was observed to have approximately one-half inch of condensation and ice buildup. The ice cream freezer was noted to	F 371	3) Dietician and dietary manager have reviewed the Refrigerated and Frozen Food Storage Policy. On 10/22/10 Dietician and dietary manager will educate dietary staff on this policy focusing on proper labeling and rotating foods for use. Dietary Manager updated cleaning schedule to include daily checks of the Refrigerator and Freezer. Any outdated or unlabeled foods will be disposed of immediately. On 10/22/2010 Dietary Manager will reeducate staff members of the importance of properly defrosting the ice cream freezer and that all problems with equipment need to be reported to her immediately. 4) Dietary Manager or her designee will monitor storage areas weekly to ensure proper food storage. Audits will be reviewed weekly by the administrator. Results will be reported to the QA committee on a quarterly basis.	11/12/2010

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F 371	Continued From page 9 have several dents and rust on the outer surface. Interview with the Dietary Manager (DM) on September 28, 2010, at 10:12 a.m., 10:25 a.m., and at 10:46 a.m., revealed items in the refrigerator were required to be dated when opened and discarded after three days. The DM stated the dietary staff was responsible to check the refrigerators daily and remove outdated items as indicated. The DM stated that items should only be kept for three days in the refrigerator from the date of opening or preparing. The DM stated that condensation buildup in the ice cream freezer could cause a freezing and thawing process, which could affect the taste and quality of the product. Note: All times documented per Eastern Daylight Time.	F 371	F465 1) The week of 10/24/2010 Housekeeping will clean corners and baseboards in B2, B4, B5, B6, B7, B8, B9, B13, B15, B16, C1, C2, C4, C6, C7, C8, C9, C10, C12, D4, D6, D7, D8, and D9. Housekeeping will clean behind toilets in B14, D2, and D8. Housekeeping will clean grout in shower room. Housekeeping cleaned the inside of the ice machine on 10/20/2010. Housekeeping and Maintenance staff members will clean air vents on hallways. The week of 10/31/2010 Housekeeping will wax and buff med room floors and will clean counters and cabinets. Prior to 11/11/2010 Maintenance Staff will sand the doors on A1, A2, A7, A10, A11, A12, A13, A15, B3, B4, B9, B10, B14, B15, C8, C10, C12, D5, D6, D7, and D11 ensuring that doors are not splintered and hazardous to our residents. Beginning on 11/1/2010 door guards and kick plates will be purchased so that	
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide effective housekeeping and maintenance services necessary to maintain a sanitary, functional, and comfortable environment for residents, staff, and the public. Missing floor tiles were observed in resident rooms, a buildup of soil was observed in corners of resident rooms, and the chests of drawers in five (5) resident rooms were observed to be scraped/scarred.	F 465		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185168	A. BUILDING _____ B. WING _____	09/29/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH AND REHABILITATION CENTER	706 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 10 The central baths on A Hall and C Hall were observed to have areas of chipped paint and the grout in the shower areas was discolored. Splintered/scarred doors and door frames were observed in twenty-one (21) resident rooms. Tiles were observed to be missing under lavatories, toilets, and air conditioners. A scraped wall and a hole were observed in the wall in two (2) resident rooms. The ice machine on the D Hall was observed to have mildew/mold on the inside. Return air vents on C Hall and B Hall were observed to have a heavy buildup of dust. Both medication rooms were observed to have soiled floors, soiled countertops, debris inside drawers, and a buildup of dirt on the floors. The medication carts were also observed to have powder/debris and dried spills on the tops/sides and inside the drawers. A tube feeding pump in the A/B medication room was observed to be soiled with a dried tan substance on it. The tube feeding support pole in A-2 was observed to be heavily soiled with a dried tan substance on it. The findings include: Observations of the facility from September 27-29, 2010, revealed the following areas were in need of maintenance/housekeeping services: 1. A heavy buildup of soil was observed at the corners of the doorframes and/or baseboards in resident rooms B-2, B-4, B-5, B-6, B-7, B-8, B-9, B-13, B-15, B-16, C-1, C-2, C-4, C-6, C-7, C-8, C-9, C-10, C-12, D-4, D-6, D-7, D-8, and D-9. 2. Splintered door edges and/or chipped doorframes were observed in resident rooms A-1, A-2, A-7, A-10, A-11, A-12, A-13, A-15, B-3, B-4, B-9, B-10, B-14, B-15, C-8, C-10, C-12, D-5, D-6,	F 465	doors can be fixed in a more attractive manor. The week of 10/17/2010 Maintenance Staff sanded and refinished chest of drawers in resident rooms B1, B3, C13, D5, and D7. Maintenance Staff have filled in holes and Scrapes in rooms C12 and D9. The week of 10/24/2010 Maintenance staff will put down tile under the HVAC units in C5, C10, D3, D7, D8, and D9. Before 11/11/2010 Maintenance Director will have an artist touch up murals in shower room. The week of 10/17/2010 Nursing staff cleaned medication carts in both medication rooms. Nursing has cleaned tube feeding pole in room A1 and poles in the med room. 2) By 10/29/2010 Housekeeping and Maintenance Supervisor will tour the entire facility to observe for safe/functional/sanitary and comfortable environment. Area needing immediate attention will	

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	185168	A. BUILDING _____ B. WING _____	09/29/2010

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 11 D-7, and D-11. 3. Chests of drawers in resident rooms B-1, B-3, C-13, D-5, and D-7 were observed to be scraped and scarred. 4. Holes/scrapes were observed in resident rooms C-12 and D-9. 5. Tiles were missing under the air conditioners in resident rooms C-5, C-10, D-3, D-7, D-8, and D-9. 6. The floor behind the toilets in resident rooms B-14, D-2, and D-8 were observed to be discolored. 7. The Central Baths on A Hall and C Hall were observed to have areas of chipped paint and soiled grout in the shower area. 8. The ice machine on D Hall was observed to have mold/mildew on the inside of the ice dispenser. 9. The return air vents on D Hall and on B Hall were observed to contain a heavy buildup of dust. 10. The medication rooms on the A/B and C/D units were observed to have soiled counters/cabinets and drawers. Debris was observed inside the drawers. The floors were observed to have a heavy buildup of dirt. 11. Medication carts in both medication rooms were observed to be soiled with dried substances, and with powder and debris in the drawers. 12. A tube feeding pole in resident room A-1 was	F 465	be addressed. A plan of action will be developed for concerns not needing immediate attention. 3) Housekeeping staff members will begin cleaning med room at 3:00pm each day. Housekeeping Manager will add med room to buffing and waxing schedule. Housekeeping Manager added cleaning the outside of the ice machine to the daily cleaning schedule, has added baseboards, corners, and behind toilets to the weekly cleaning schedule, has added cleaning the inside of the ice machine to the quarterly cleaning schedule and the air vents to the monthly cleaning schedule. On 11/5/2010 Housekeeping Manager will educate the housekeepers on the new cleaning schedule. On 11/5/2010 DON will reeducate staff members on the nursing cleaning schedule and on proper cleaning techniques. Dirty tube feeding poles will be placed in the soiled utility room.	

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	185158	A. BUILDING _____ B. WING _____	09/29/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH AND REHABILITATION CENTER	796 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167

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F 465	Continued From page 12 observed to have a heavy buildup of a dried tan substance. A tube feeding pump in the A/B medication room was observed to be heavily soiled with a dried tan substance. An interview with the Maintenance and Housekeeping Supervisors was conducted during the environmental tour at 10:00 a.m. on September 29, 2010. The Supervisors stated that they attempted to make facility rounds weekly to observe for maintenance and cleaning needs.	F 465	Clean poles will be placed in the med room. Maintenance staff members will begin refinishing or purchasing one chest of drawers per week. Over the next year Maintenance staff will apply kick plates and door guards to all doors in the facility. Holes and Scrapes in rooms will be fixed weekly after reported to maintenance by the room round committee. Maintenance staff members will ensure touch up paint in shower rooms at least quarterly. 4) The housekeeping manager or her designee will check five resident rooms, the ice machine, the air vents, the shower rooms and the med room weekly for cleanliness. DON will check med cart for cleanliness monthly. The Maintenance Director will turn in a Job Task Sheet to the Administrator weekly. The Administrator will ensure that the maintenance staff are following job task schedule. All monitoring will be reported to	

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	100337	A. BUILDING _____ B. WING _____	09/29/2010

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MONROE HEALTH AND REHABILITATION CEN	706 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167

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			the QA committee on a quarterly basis.	11/12/2010

STATE FORM 6899 TQHT11

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	185168	A. BUILDING _____ B. WING _____	09/29/2010

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F 318	Continued From page 3 completed on April 12, 2010, revealed resident #5 was assessed to have limited range of motion of the left hand and to require extensive to total assistance of staff for transfers, bed mobility, hygiene, and bathing. A review of the quarterly joint mobility and restorative screen conducted on April 5, 2010, revealed resident #5 was assessed to be able to passively make a fist and fully open the right hand; however, the resident was identified to keep the left hand clinched. The screening also noted the left and right hands were within functional limitation (WFL). The screen noted WFL was defined as having 75 to 100 percent of available range of motion. A review of the restorative care plan for resident #5 revealed the facility had identified the resident to be at risk for contracture development due to weakness. Interventions included to provide active assist range of motion (ROM) exercises to bilateral upper and lower extremities at least 15 minutes daily and to report any decline in ROM to the charge nurse or restorative nurse for further evaluation. However, there was no evidence the facility had developed individualized interventions to address the resident's impaired ROM of the hands. Resident #5 was observed on September 27, 2010, at 3:30 p.m., at 4:30 p.m., and at 5:40 p.m., to be lying in bed on a wedged mattress with a pillow underneath the resident's knees. A handroll was observed to be lying on the resident's bedside table. A skin assessment conducted on September 28, 2010, at 10:55 a.m., revealed the facility staff nurse was able to flex resident #5's right hand with some stiffness	F 318	quarterly. Individualized interventions will be put on the care plan. DON, ADON and therapy will meet monthly to discuss any issues. 4) For the next three months (November, December, January) DON will perform audit on at least five residents per month to ensure resident has been assessed accurately and care planned for their specific problems. DON will report results to the QA committee quarterly.	11/12/2010

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Addendum

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F 364	Continued From page 6 degrees Fahrenheit. A surveyor and the Dietary Manager conducted palatability tests of the meal with both noting the fish, potatoes, and macaroni and cheese were warm and bland to taste. The Dietary Manager stated the milk and shake were warm and not as cold as they should have been. Observations were conducted on September 27, 2010, during the dinner meal tray pass on the D Wing. Observation revealed the first meal tray was passed at 6:32 p.m., and the last meal tray was passed at 7:02 p.m., 30 minutes later. The last meal tray was intercepted by two surveyors along with the presence of the Dietary Manager. Temperatures were taken of the fortified liquid diet meal. Temperatures were noted as follows: sweet potatoes - 112 degrees Fahrenheit, ham - 120 degrees Fahrenheit, bread with milk - 80 degrees Fahrenheit, milkshake - 56 degrees Fahrenheit, and Vitamin D milk - 48 degrees Fahrenheit. After a palatability test was completed, the Dietary Manager stated the food was barely warm, was bland, and he/she would have sent the food back to the kitchen at these temperatures. Further observations were conducted on September 28, 2010, at 8:43 a.m., on the B Wing during the breakfast meal. Observation revealed the last meal tray was intercepted at 9:12 a.m., due to the extended timeframe of meal delivery to the residents. The meal tray was intercepted by two surveyors and the DM. Temperatures of the puree diet were as follows: oatmeal - 118 degrees Fahrenheit, bacon - 102 degrees Fahrenheit, eggs - 90 degrees Fahrenheit, gravy - 88 degrees Fahrenheit, and Vitamin D milk - 48 degrees Fahrenheit. The Dietary Manager stated the food temperatures were not acceptable.	F 364	10/22/2010 Dietician and dietary manager will reeducate dietary staff on the Serving Temperature Policy and on the Tray Delivery Policy. Dietary staff will be educated on the revised temperature recording logs and procedures. Dietary Manager ordered new wells and lids for the steam table, dietary staff members are ensuring that the plate warmer is kept at its warmest temperature, cold products are put in the freezer prior to meals being served, and steam table element was fixed by maintenance staff. The order of tray pass has been changed so that trays are served in a timely manner. 4) For the next three months (November, December, January) Dietary Manager, Administrator, and DON will perform test tray audits weekly. Results will be reviewed by the NAR committee weekly. Dietary Manager will report results to the quarterly QA committee.	11/12/2010

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F 371	Continued From page 8 by: Based on observation and interview, the facility failed to store, prepare, and distribute foods under sanitary conditions. The findings include: Observations were conducted with the Dietary Manager of the kitchen refrigerator on September 28, 2010, at 10:25 a.m. (EDT). The following items were observed to be outdated and stored in the kitchen refrigerator: One container of diet pears, dated September 18, 2010. One container of Parmesan cheese, dated May 11, 2010. One jar sweet relish, opened and partially used, not dated. One-half container of shredded cheese, dated September 15, 2010. One pitcher of diet orange drink, dated September 21, 2010. One pitcher of diet lemonade, dated September 16, 2010. One container thickened dairy milk, dated September 17, 2010. One container sweetened tea, dated September 24, 2010. One container thickened punch, dated September 24, 2010. Observation of the kitchen conducted on September 28, 2010, at 10:45 a.m., revealed an ice cream freezer with the lid broken, seal not intact, and foam inside of the lid visible. The ice cream freezer was observed to have approximately one-half inch of condensation and ice buildup. The ice cream freezer was noted to	F 371	3) Dietician and dietary manager have reviewed the Refrigerated and Frozen Food Storage Policy. On 10/22/10 Dietician and dietary manager will educate dietary staff on this policy focusing on proper labeling and rotating foods for use. Dietary Manager updated cleaning schedule to include daily checks of the Refrigerator and Freezer. Any outdated or unlabeled foods will be disposed of immediately. On 10/22/2010 Dietary Manager will reeducate staff members of the importance of properly defrosting the ice cream freezer and that all problems with equipment need to be reported to her immediately. 4) For the next three months (November, December, January) Dietary Manager or her designee will monitor storage areas weekly to ensure proper food storage. Audits will be reviewed weekly by the administrator. Results will be reported to the QA committee on a quarterly basis.	11/12/2010

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F 465	Continued From page 12 observed to have a heavy buildup of a dried tan substance. A tube feeding pump in the A/B medication room was observed to be heavily soiled with a dried tan substance. An interview with the Maintenance and Housekeeping Supervisors was conducted during the environmental tour at 10:00 a.m. on September 29, 2010. The Supervisors stated that they attempted to make facility rounds weekly to observe for maintenance and cleaning needs.	F 465	Clean poles will be placed in the med room. Maintenance staff members will begin refinishing or purchasing one chest of drawers per week. Over the next year Maintenance staff will apply kick plates and door guards to all doors in the facility. Holes and Scrapes in rooms will be fixed weekly after reported to maintenance by the room round committee. Maintenance staff members will ensure touch up paint in shower rooms at least quarterly. 4) For the next three months (November, December, January) The housekeeping manager or her designee will check five resident rooms, the ice machine, the air vents, the shower rooms and the med room weekly for cleanliness. DON will check med cart for cleanliness monthly. The Maintenance Director will turn in a Job Task Sheet to the Administrator weekly. The Administrator will ensure that the maintenance staff are following job task schedule. All monitoring will be reported to	

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	185168	A. BUILDING _____ - MAIN BUILDING 01 B. WING _____	09/29/2010

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K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on September 29, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "E" level.	K 000	K025 NFPA Life Safety Code Standard 1) Maintenance Director contacted Lyons HVAC service. Lyons HVAC service will perform damper inspection on 10/22/2010.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain fire/smoke dampers that penetrated the fire/smoke barrier walls in the attic area. This deficient practice affected three (3) of six (6) smoke compartments, staff, and approximately fifty-two (52) residents. The facility has the capacity for 104 beds with a census of 104 on the day of the survey. The findings include:	K 025	2) On 10/22/2010 Maintenance Director checked attic to ensure that all dampers have been inspected. 3) Maintenance Director has revised Preventative maintenance list to include maintenance on dampers at least every four years. 4) Maintenance Director has informed the TELS programmer to add damper inspection every four years to facility PM schedule. TELS program will remind maintenance director when damper inspection is due.	11/12/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mitzy Cook — TITLE: Administrator — (X6) DATE: 10/20/201

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	185168	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/29/2010

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K 025	Continued From page 1 During the Life Safety Code survey on September 29, 2010, at 11:15 a.m., with the Director of Maintenance, a fire/smoke barrier wall above the fire doors on the C Wing was observed to have ductwork that contained a fire/smoke damper. A fire/smoke damper closes to prevent fire and hot gases from penetrating the fire/smoke barrier wall and is required to be inspected and maintained every four years. An interview with the Director of Maintenance on September 29, 2010, at 11:15 a.m., revealed the Director of Maintenance was unaware of the requirements pertaining to fire/smoke dampers or if there was a record of the dampers having been maintained. The Director of Maintenance stated there was also a fire/smoke damper on the D Wing. Reference: NFPA 90a (1999 Edition). 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.	K 025		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029	K029 NFPA 101 Life Safety Code Standard 1) On 10/18/2010 Maintenance Director installed door closures on the corridor door to the laundry room and the medical supply rooms.	

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MONROE HEALTH AND REHABILITATION CENTER	706 N MAGNOLIA STREET, PO BOX 357 TOMPKINSVILLE, KY 42167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that hazardous area doors were equipped with a self-closing device. This deficient practice affected two (2) of six (6) smoke compartments, staff, and approximately twenty-six (26) residents. The facility has the capacity for 104 beds with a census of 104 on the day of the survey. The findings include: During the Life Safety Code tour on September 29, 2010, at 10:55 a.m., with the Director of Maintenance, a corridor door to the Laundry and Medical Supply rooms were observed not to have door closing devices. Door closing devices are required on doors to rooms deemed to be a hazardous area. An interview on September 29, 2010, at 10:55 a.m., revealed the Director of Maintenance was unsure which rooms were considered hazardous areas that would require a door closing device. Reference: NFPA 101 (2000 Edition). 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be	K 029	2) On 10/18/2010 Maintenance Director observed other doors throughout the building and determined door closures were on all necessary doors. 3) On 10/18/2010 Maintenance Director installed door closures. On 11/5/2010 all staff members educated on importance of door closures. 4) Maintenance Director will check doors to hazardous areas monthly to ensure door closures are on doors. QA results will be reported to the QA committee quarterly.	11/12/2010

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185168	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/29/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE HEALTH AND REHABILITATION CENTER	706 N MAGNOLIA STREET, PO BOX 367 TOMPKINSVILLE, KY 42167

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K 029	Continued From page 3 separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. 19.3.6.3.4 Door-closing devices shall not be required on doors in corridor wall openings other than those serving required exits, smoke barriers, or enclosures of vertical openings and hazardous areas.	K 029		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in	K 056	K056 NFPA 101 Life Safety Code Standard 1) Maintenance Director contacted Eagle Fire Protection. Eagle Fire Protection began installing sprinklers the week of 10/17/2010	

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K 056	Continued From page 4 accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the outside canopies at the facility were of noncombustible or limited combustible construction or sprinkler protected as required. This deficient practice affected one (1) of six (6) smoke compartments, staff, and six (6) residents. The facility has the capacity for 104 beds with a census of 104 on the day of the survey. The findings include: During the Life Safety Code survey on September 29, 2010, at 11:30 a.m., with the Director of Maintenance, two combustible canopies exceeding four feet in width located at the front entrance and smoking area of the facility were observed not to be sprinkler protected. Combustible canopies exceeding four feet in width must be sprinkler protected. An interview with the Director of Maintenance on September 29, 2010, at 11:30 a.m., revealed he/she was not aware of this requirement. Reference: NFPA 13 (1999 Edition). 5-13.8.1	K 056	2) The facility has no other porches that exceeds four feet without sprinklers 3) Maintenance Director contacted Eagle Fire Protection. Eagle Fire Protection began installing sprinklers the week of 10/17/2010. 4) Maintenance Director will ensure that sprinkler heads are inspected on a quarterly basis by Eagle Fire Protection.	11/12/2010

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K 056	Continued From page 5 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056		